'Refusing treatment—please see': an analysis of capacity assessments carried out by a liaison psychiatry service

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SUMMARY

The assessment of capacity to consent to a healthcare decision is an important part of day-to-day work in general hospitals. The role of liaison psychiatric services in assessment of capacity has not been well studied in British practice. We looked at all such referrals (35) to a liaison psychiatric service in a teaching hospital in the course of one year.

The commonest referrals were regarding capacity to consent to a therapeutic procedure, followed by post-discharge placement and ability to self-discharge. Organic mental disorders were the most frequent cause of incapacity. 20 (57%) of the referrals were for patients who had refused the intervention in question, and in 12 of these the contentious issue was resolved.

Liaison psychiatric services can be useful not only in offering a second opinion or clarifying the influence of psychopathology on decision-making ability but also mediating between the patient and the clinical team.

INTRODUCTION

The assessment of capacity to consent to medical treatment has become increasingly relevant with the introduction of the Adults with Incapacity (Scotland) Act 2000 and the planned introduction of the Capacity Act in England and Wales. Many patients in general hospitals lack capacity to consent to treatments, although the issue is infrequently recognized.[1] The assessment of mental capacity is supposedly a core skill for all postregistration doctors but many seem to find it difficult.[2] When questions about capacity to consent to a healthcare decision are raised on general hospital wards, liaison psychiatry services are often involved.

Not many studies on capacity assessments have been conducted in general hospitals by psychiatrists.[3,4] There are three situations where the liaison psychiatrist may be requested to assess capacity—(*a*) where there is a psychiatric disorder influencing decision-making capacity; (*b*) where the referral is made by the physician to avoid an adversarial relationship with the patient; and (*c*) where the decision is so complex as to demand the skills of a person expert in such assessments.[5] Looking at covert and overt aspects of capacity referrals, Umapathy *et al*.[6] in Philadelphia suspected that capacity referrals are commonly disguised referrals in cases where the medical team find it difficult to manage patients. The issue deserves examination in British liaison psychiatric practice since there is debate within the profession about the appropriateness of such consultations.[7,8]

METHODS

This was a case series conducted in the Department of Psychological Medicine at King's College Hospital, a teaching hospital in South London. All psychiatric consultations conducted by the liaison psychiatry service where capacity to consent to a healthcare decision was assessed were recorded on a specially devised form. It contained sociodemographic details, reasons for referral, as well as details of capacity assessment including the three components of the legal definition of capacity—the ability to understand and retain information; the ability to believe information; and the ability to weigh the information in balance. Most of the assessments were done by senior house officers in liaison psychiatry according to guidelines suggested by Appelbaum and Grisso,[9] under the supervision of a senior psychiatrist.

RESULTS

35 cases were identified during one year. 57% of the patients were male and the median age was 58 (range 26–89). Table 1 gives the reasons for referrals: in 40% the

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Table 1 **Healthcare decision where capacity was queried (*N*=35)**

Decision in question	*No. of patients (%)*
Therapeutic procedure	14 (40)
Placement after discharge	9 (25.7)
Self discharge against advice	4 (11.4)
Medication	1 (2.9)
Investigation	3 (8.6)
Mixed (more than one of above)	2 (5.7)
Other	2 (5.7)

Table 2 **Concordance in capacity assessments (*N*=31)**

	Medical team: capacity present	*Medical team: capacity absent*	*Medical team: undecided*
Psychiatrist: capacity present	11	3	3
Psychiatrist: capacity absent	1	8	2
Psychiatrist: undecided	2	1	0

question related to a therapeutic procedure, in 26% to placement following discharge and in 11% to the ability to self-discharge against medical advice. Of the 13 patients judged to lack capacity, 9 had an organic mental disorder, most commonly dementia. Table 2 shows the concordance of capacity judgment between the medical team and the assessing psychiatrist in 31 patients for whom this information was available. In the 23 cases where both clinical teams reached a clear decision about capacity, the overall agreement was 83% with a kappa of 0.65 indicating good inter-rater agreement.

Of the 35 referrals, only 20 (57%) were for patients who had refused the proposed intervention. Of those 20, capacity was judged to be absent in 9 and present in 8, judgment being deferred in 3. In 12 patients initially refusing the proposed intervention, the contentious issue was resolved after the psychosocial assessment, with either the patient agreeing to the intervention or the team negotiating an option more acceptable to the patient.

DISCUSSION

This study was not an attempt to estimate the rates of capacity referrals and we did not include the referrals out of hours. We acknowledge that some consultations where the assessment of capacity was not the main focus may have slipped the net. The low age of our sample reflects the fact that part of the old-age liaison service is delivered at a different site of the hospital not covered by this study.

We were able to identify three types of referrals. The first was where the referring team had concluded that capacity was present but wanted a second opinion. Such assessments may be requested even when the patient has not refused the treatment or procedure in question. This was the case when the procedure was one without a clear benefit to the person such as the donor in live-donor liver transplantation. In the second type, the referring team had no doubt about lack of capacity but a referral was made to back up this assessment. This is likely to happen, for example, when there are placement issues in a patient. The impetus for such referrals may come from agencies such as the social services, which require a psychiatric opinion. The third type was where the clinical team had a genuine doubt about capacity and wanted the psychiatric team to clarify the issue.

Whereas many of the cases tested in the courts have been dramatic and involved 'life and death' decisions, most of our cases involved routine medical procedures and aftercare issues where the stakes were lower. In many cases, the issue was resolved or a negotiated decision was arrived at after the assessment. While we are not able to demonstrate cause and effect, the spirit of engagement and negotiation engendered by the psychiatric assessment often seemed to contribute to a resolution.

Liaison psychiatric services can serve a useful function in assessment and management of patients when questions are raised about capacity to consent to a healthcare decision. The input may be in the form of a second opinion or a comment on the contribution of psychiatric illness to decision-making ability; but in some cases the psychiatrist acts as a mediator between the team and the patient. For the best use of liaison psychiatry, which in most settings is a scarce resource, explicit criteria for referral are desirable. The referring team should try to present the information in a manner that enhances comprehension,[10] with a clearly formulated question that needs to be answered.

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